Care Quality Commission

Advinia Care Homes Limited

Ryland View Care Home

Inspection report

Arnhem Way
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West Midlands
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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection of the service took place on 04 and 04 July 2018. This was the first inspection of the service since it was registered under a new provider in December 2017.

Ryland View is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Ryland View accommodates up to 144 people across five separate units, each of which have separate adapted facilities. Mamby unit provides short term step down support for people, Palethorpe unit is specifically for younger adults with physical disabilities, Heronville unit alongside Bloomfield unit provides Dementia care and Haines Unit is for people who require general nursing care. At the time of the inspection there were 135 people living across the five units.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were supported by staff who understood how to act on concerns about abuse and manage risks to keep them safe. There were sufficient numbers of appropriately recruited staff available for people. There were good infection control practices in place and medications were given in a safe way.

People were supported by staff who received training in their role. Gaps in training had been identified and acted upon by the provider. People were supported to eat and drink and had access to healthcare services where required. People's rights had been upheld in line with the Mental Capacity Act although staff knowledge around Deprivation of Liberty safeguards varied. The design and decoration of the service met peoples needs.

People were supported by staff who were kind and caring. People were treated with dignity and respect and had their communication needs met. Advocacy services were available for people where required.

The availability of activities varied across units which meant some people had more meaningful experiences than others. People's care needs were assessed and reviewed. Care records held personalised information about people and staff knew people well. Complaints made had been investigated and resolved.

People, relatives and staff spoke positively about the leadership at the service. Audits were in place to monitor the quality of the service and people were given opportunity to feedback on their experience of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

People were supported by staff who knew how to manage risks to keep them safe.

There were sufficient amounts of staff available to support people.

Medications were managed in a safe way and there were safe infection prevention procedures in place.

Is the service effective?

Good

People were supported by staff who received appropriate induction and training.

Meals provided met people's dietary needs and people had access to healthcare services where needed.

People's rights were upheld in line with the Mental Capacity Act.

People's needs were met in terms of the design and decoration of the service.

Is the service caring?

Good

People were supported by staff who were kind and caring.

People's communication needs were met.

People were treated with dignity and had opportunity to access advocacy services where required.

Is the service responsive?

Requires Improvement

The availability of activities varied across units which meant some people had more positive experiences than others.

People's care needs had been assessed and reviewed. People's end of life needs had been assessed and met where required.

Complaints made had been investigated and responded too.

Is the service well-led?

Good

People and staff spoke positively about the management of the service.

There were audits in place to monitor the quality of the service.

People were given opportunity to feedback on their experience of the service.

Care Quality Commission

Ryland View Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

The inspection was prompted in part by a series of safeguarding concerns raised about the service. These related to staffing levels and the quality of care. We looked at this as part of the inspection.

This inspection took place on 04 and 05 July 2018 and was unannounced. The inspection team consisted of four inspectors, a specialist advisor who was a registered nurse and an expert by experience. An expert by experience is a person who has experience of using or caring for a person who uses this type of care service.

We reviewed information we held about the service, this included information received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. Due to technical problems, the provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the local authority to gather their feedback about the service.

We spoke with four people and five relatives. As some people were unable to share their experience of the service, we completed a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with seven care staff, one senior carer, three nurses, two activity co-ordinators, three unit managers, an assistant cook and the registered manager.

We looked at care records for 12 people and 28 medication records. We also looked at three staff recruitment files, training records, accidents and incidents and complaints. We reviewed records held in relation to monitoring the quality of the service.

Good

Is the service safe?

Our findings

People across all five units told us they felt safe at the home. One person said, "I am very happy here". A relative we spoke with added, "I have found it to be pretty good here, it's great here". Staff we spoke with understood the different types of abuse and how they could report any concerns they had. One member of staff told us, "If I witnessed anything, I would tell the manager, who then reports it to the safeguarding team [at the local authority] or the police".

We found that risks were managed to keep people safe. Some people had developed pressure areas prior to moving into the home. Staff had managed this risk well and we saw that as a result of this intervention, people's pressure areas had improved. For example, we saw that for one person who had a pressure area, staff had ensured the proper use of pressure relieving equipment, supported the person to reposition regularly and photographed the wound to monitor its progress. This had ensured a gradual improvement of the person's health in relation to their skin integrity.

Where people had fallen or were at risk of falls, risk assessments had been completed to ensure people were safe. We saw these risk assessments clearly detailed how people should be supported with their mobility to reduce the risk of falls.Staff knowledge reflected what was in the care records. We saw where people's falls risks had changed due a deterioration in their health, the records were updated to reflect the support needed. Where new risks were identified, we saw that the registered manager responded appropriately to ensure people's safety. For example, we observed staff supported people with their mobility and saw that this was mostly done in a way. However, on Heronville unit, we saw that staff were supported people to stand in a way that could have increased their risk of falls. Staff supported people by holding their hands while they stood, rather than encouraging them to push themselves up using the arms of the chair. This would have been the safest way to support the person to stand. We raised this with the registered manager who had already identified that some improvements were required to the moving and handling support given by staff and had sourced specialist advisors to visit the home and provide guidance to staff. The registered manager had also arranged for additional training for senior members of staff that would enable them to train others in safe moving and handling. This action would ensure that there was always a member of staff available to guide and train staff in how to move people safely. This showed that where risks had been identified, the registered manager had been pro-active in addressing these to ensure the safety of people.

Staff told us that prior to commencing employment, they had been required to complete checks that included providing two references from previous employers and completing a check with the Disclosure and Barring Service (DBS). The DBS would show if a staff member had a criminal record or had been barred from working with vulnerable adults. Records we looked at confirmed that these checks had taken place.

Prior to the inspection, we had received information that suggested there were not enough staff to support people. At this inspection people told us they felt there were enough staff available to meet their needs. One relative told us, "There always seems to be plenty of them [staff] around in the lounge". People who chose to stay in their room told us that staff remained available if needed. One person said, "The carers pop in from

time to time to make sure I am alright" and another person added, "They [staff] check on me throughout the night, I have seen and heard them come into me, probably every few hours". Staff we spoke with were also positive about the staffing levels and felt that they were not rushed in their work. One member of staff told us, "There is enough staff to keep people safe".

Our observations across all units indicated there were enough staff to keep people safe, we saw that there were staff within communal areas and that where people called for support, this was provided in a timely way. The registered manager had used a dependency tool to assess how many staff were needed across the units and systems were in place to ensure appropriate staffing levels where staff had called in sick. This included using staff from other units to cover staff absence at short notice.

People were kept safe as staff ensured they followed guidance in relation to infection prevention. We saw that staff ensured they used Personal Protective Equipment (PPE) when supporting people or handling foods and the home was noticeably clean and odour free. The registered manager had identified that training in infection prevention would support the current good practice being shown across the units and informed us that the completion of this training was the provider's priority.

People were satisfied with the support they received with their medication. One person told us, "I take plenty of tablets and I have them around the same time everyday". We observed nurses supporting people to take their medication and this was done in a safe way. We saw that the nurses told people that it was time to take their medication and stayed with them while they took this. We found that staff did this in a manner that allowed the person to take their time and were patient with people throughout.

Where people required medication on an 'as and when required' basis, there were protocols in place informing staff of when these should be given. These protocols advised staff of people's individual experience of pain so that people could be given these medications in a consistent way. Some people required their medication via a PEG. This is a way of providing medications and food via a tube inserted into the stomach. Where people required a PEG, there were clear directions for staff on how this should be managed, including how to position the person when giving their medication and how to detect signs of infection. Where people had medications that came with specific instructions, such as being given 30 minutes before food, staff had followed these instructions.

We looked at the Medication Administration Records (MAR) completed by staff and these indicated that medication had been given as prescribed. Where medication was given, this had been signed for and the medication counts showed that these had been given correctly.

The registered manager showed a willingness and openness to learning from incidents to improve the safety of the service. For example, an analysis completed by the manager of accidents and incidents at the home indicated that a high number of incidents occurred during the evening. To address this, the registered manager altered the times that staff worked to ensure there were extra staff available during these times to reduce the risk of further incidents. This showed that where things went wrong, the registered manager was able to reflect on this and make changes to keep people safe.

Good

Is the service effective?

Our findings

People told us that they felt that staff had the skills and knowledge required to support them effectively. One person told us, "The carers are very good, they are very knowledgeable and respectful". A relative added, "The carers look after my relative really well".

Staff told us that prior to commencing work, they had been required to complete an induction that included completing training and shadowing a more experienced member of staff. One member of staff told us, "I was enrolled on the Care Certificate and I have 12 weeks to complete this. I have been shadowing a senior, they have been giving me a lot of support". We saw that new staff were being enrolled on the Care Certificate. The Care Certificate is an identified set of standards that care workers must adhere too. Staff told us that following their induction, they were required to complete updates to their training. One member of staff told us, "We get training on everything, it's all quite good. We can ask for additional training. The provider will send out a list and we can pick what we want to do". Records we looked at showed that while training was being completed, not all staff had completed the required courses. We spoke with the registered manager who had identified that some training updates were required and was in the process of arranging these. The registered manager explained that the updates had not been provided due to the changeover of provider and that they were addressing this as a priority.

People told us they were happy with the meals they were provided with. One person told us, "Lovely food and plenty of it. Plenty of drinks too". Another person said, "The food is alright, I don't feel that I am missing out on that I used to have when I was at home". We saw that mealtimes were a relaxed experience. People could choose where they had their meals and were seen talking with staff throughout their meal. People who required support to eat were provided with this in a discreet and sensitive manner and those who required encouragement to eat were supported by staff.

Where people were at risk of weight loss, we saw that action had been taken to monitor this and support people to maintain a healthy weight. For example, we saw that one person had been identified as losing weight. The service commenced a fortified diet that would provide extra calories and continued to monitor the person. Where further weight loss was found, referrals were made to a dietician to investigate further and ensure the person's wellbeing.

People had access to healthcare services to support their health and well-being. People told us they were able to see a GP when needed. One person said, "I get visits from the GP if I am ill and a podiatrist comes in regularly to see me". Records we looked at showed that people had been supported to access a number of services including; Speech and Language Therapy, Physiotherapy as well as routine appointments with opticians and dentists.

The design and decoration of the home met people's individual needs. The home was split into five separate buildings, and each building had its own lounge area, dining room, bathrooms and gardens. The units were spacious and decorated to suit people's needs. For example, we found that on Heronville unit, the layout of the seating in the living room had been altered to provide people with more room to move safely as there

were people on the unit who were at risk of falls. This showed that the provider had thought about people's needs when planning the decoration of the unit.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. Staff we spoke with understood the importance of seeking consent before supporting people and could describe the ways in which they do this. One member of staff told us, "I am always reading the care plans and asking people for their permission. The care plans will say what people can and can't decide or if they need assistance". Another staff member added, "We speak to people and ask them [for permission]. It is all up to the person".

We found that some people had DoLS authorisations in place and that these had been applied for appropriately. Staff knowledge of what these authorisations meant and who had one in place varied. On Palethorpe unit, we found that staff could explain who had DoLS authorisation in place, and how this impacted on the support they should provide. On Heronville and Bloomfield, we found that some staff were not confident in DoLS and could not recall who had an authorisation in place. Without this knowledge of who has a DoLS authorisation and any associated conditions on these, we could not be sure that people were always supported in line with the authorisations, although we did not see any staff practice that would indicate that people were being unlawfully deprived of their liberty. We saw that staff had received training in MCA/DoLS and the registered manager informed us that this information had been shared with all staff but that this would be re-iterated to ensure that all staff are aware of who had an authorisation in place.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring to them. One person told us, "Everybody is kind and they [staff] look after me". Another person said, "I like all of the carers very much". This view was shared by relatives. One relative told us, "The carers are really good. They really care, they are polite and friendly and they know what they are doing". We saw examples across all five units of positive relationships being developed between people and the staff supporting them. Staff were seen to be laughing and joking with people and took time to sit and speak with people throughout the day. We saw examples of staff going above and beyond to display caring behaviours to people who were no longer at the home. On Mamby unit, we found that where people were leaving the unit to return home before Christmas time, staff had put together food hampers as gifts so that the person would have enough food to enjoy a Christmas dinner. We saw thank you cards from people who had received these gifts and the positive impact this had on their Christmas.

Where people had specific communication needs, these were being met. We found that some people at the home did not speak English as a first language. Staff on Heronville and Palethorpe unit told us that they had taken time to learn some basic words in the person's chosen language to support their communication with the person. Staff spoke a few words to us in this language to evidence their learning. Where more complex communication was required, there were systems in place to ensure effective communication. This had included locating staff members on other units who were able to speak the person's language fluently. We were told by staff that this had been an effective system and they had not encountered a time where they could not find a member of staff to communicate with the person.

People told us they felt involved in their care and were given choices. One person told us, "I like to get up early in the morning, I get up at the time that I want". We saw that people were given choices throughout the day and this included what they would like to eat and where they would like to spend their time. People felt they were treated with dignity and respect and our observations reflected this. For example, we saw that staff knocked doors and waited for consent before entering people's rooms and that people were referred to by their chosen names.

People were supported to maintain their independence where possible. We saw that people were being encouraged to walk independently where possible and that snack bars had been set up to encourage people to help themselves to food and drink. We saw people using this throughout the day.

People had access to advocacy services where required. An advocate can be used when people may have difficulty making decisions and require this support to voice their views and wishes. We spoke with the manager who was aware of how to make referrals for advocacy support for people where required.

Requires Improvement

Is the service responsive?

Our findings

People gave mixed feedback on the activities provided at the home. One person told us, "I have opportunities to go outside but I don't want too, I am quite happy not be involved in activities but I am always asked if I would like too". One relative added, "They had a garden party the other week, there was a singer and [person's name] seemed to really enjoy it". Other relatives we spoke with felt that activities that were planned were not always open for their loved one. One relative told us, "They had a garden party and it was a shame as they only took people out that were able to walk, my relative had to stay inside as I was unable to push her in a wheelchair". We also spoke with one of the activity co-ordinators at the home who informed us that a trip to the seaside was coming up but that there were limited spaces and so not everyone would be able to attend. We spoke with the registered manager about this who told us that there were no exclusions for any activities and that people who wished to attend any event, would be supported too.

We found that the availability of activities varied across each unit. Whilst some units appeared to have a variety of activities throughout the day including Karaoke, bingo and quiz sessions, other units were quiet and people did not have activities as readily available. We spoke with the registered manager about this who advised that each unit had their own activity co-ordinator who would be responsible for activities and so activities should be available for people on each unit. However, this was not reflected in our findings on the day of our visit.

Prior to moving into the home, people had been involved in an assessment of their needs. These assessments included looking at people's medical history and current care needs. These assessments also considered any protected characteristics under the Equality Act such as religious needs and sexuality.

We found that care records were updated where people's needs had changed and that people's preferences with regards to their care had been considered. For example, we saw that people had been asked if they had a gender preference for who provided their care and had been consulted about how they wish to spend their day. We saw that where people's needs had changed, short term care plans had been implemented. For example, on Mamby unit, we saw that one person's needs with regards to a health condition had recently changed and that emergency assistance had to be requested. This was documented and the person's fluctuating needs in regards to this health need had been clearly recorded in a short term care plan to reflect the new position the person was in. This ensured that all staff had access to the most up to date information about the person. Staff we spoke with were knowledgeable about people and spoke confidently about how they should meet people's individual needs. For example, staff on Mamby unit were aware of one person's preferred skin cream, had ensured this was applied and commented on the lovely smell of this when they saw the person. Staff on other units clearly had taken time to learn about people's life history and this displayed in their conversations with people.

Some people living at the home required end of life care. For these people we saw that there were care plans in place that detailed how they should be supported at the end of their life and any specific wishes they had in their final days including where they would wish to be cared for and any religious requirements. Relatives we spoke with regarding end of life care spoke positively about their experience. The relative told us, "For

our relative to have had the best care means so much to us, [person's name] was happy. The staff made them feel very important, they focused on what was important to [person's name] and involved us so we all knew the plan. If this was my staff, I would be very proud of them".

People told us they knew how to make a complaint if needed. One person told us, "I would speak to [unit manager's name] if I had any problems". We saw that details were displayed on each unit informing people of how they could complain if they wished and where needed this was in an accessible format. We looked at records held on complaints and could see that complaints made had been investigated and a full response provided to the complainant.

Good

Is the service well-led?

Our findings

People told us they felt that the home was well led and that they were happy with the home. One person told us, "I am very happy here". Another person said, "The manager comes to see me regularly and asks me if I am ok or if I have any problems". A relative we spoke with added, "We are very happy with the carers and the home, they all love [person's name] and they are very settled".

Staff we spoke with felt supported by the registered manager. Staff confirmed that they received regular supervisions and were able to raise concerns if they had any. Staff felt that any concerns raised would be acted upon by the registered manager. All staff spoken with were aware of how to whistle blow if they had concerns that hadn't been responded too. The registered manager held daily meetings with managers from each of the five units to discuss any issues on the units and a weekly clinical risk meeting was held with nurses to address any nursing issues that may have arisen. This ensured that the staff who manage the units, had opportunity to discuss the care provided on a regular basis with the registered manager.

We saw that systems were in place to monitor the quality of the service. These included managers spot checks that looked at care records, medication and staff competencies. Where these audits identified areas for improvement, we could see that these were being acted upon. A monthly analysis was also completed that analysed accidents, Medication errors, pressure areas and people's weights to ensure that risks were being managed appropriately. Where trends or patterns were identified, we saw that actions to address this had been recorded. For example, we saw that the analysis of falls had led to changes in the seating layout of the units. These audits were completed for each of the five units of the home so that areas for improvement could be identified per unit.

People were given opportunity to feedback on the quality of the service. One person told us, "My relative gets involved in meetings and then tells me what went on". We saw posters displayed across the units that advertised resident's meetings and an open surgery in which people and their relatives could see the registered manager without appointment once a week. One Heronville unit we saw that there was a 'You said, we did' board that showed how the unit managers had acted upon the feedback given to them by people. We saw on the board that people had requested more drinks and snacks to be available. The unit manager had responded to this by introducing a snack bar that people could access when they chose throughout the day. This showed that people's feedback was acted upon to improve the service provided.

It is a requirement that providers inform us of certain incidents that occur at the service. We checked to see what notifications we had received and found that the registered manager had submitted notifications of incidents appropriately.

The registered manager felt supported in their role and had clear plans for the future of the service. They showed us their ongoing plans to improve the services provided and this included developing a cinema room.